		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0018275

Facility Name: Alpine Fireside Health Center

Address: 3650 North Alpine Road (Number) Rockford (City) 61114 (Zip Code)

County: Winnebago

Telephone Number: (815) 877-7408 **Fax #** (815) 877-9818

IDPA ID Number: 362753251001

Date of Initial License for Current Owners: 1973

Type of Ownership:

	VOLUNTARY,NON-PROFIT			x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.				Individual		State
	Trust				Partnership		County
IRS Exemption Code					Corporation		Other
				x	"Sub-S" Corp.		
					Limited Liability Co.		
					Trust		
					Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-4580
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/2003 to 09/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 04/05/2004

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)	32	5,728	1
2		Skilled Pediatric (SNF/PED)			2
3	63	Intermediate (ICF)	30	17,151	3
4		Intermediate/DD			4
5	31	Sheltered Care (SC)	31	11,346	5
6		ICF/DD 16 or Less			6
7	94	TOTALS	93	34,225	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			187	187	8
9	SNF/PED					9
10	ICF	9,452	7,016		16,468	10
11	ICF/DD					11
12	SC		8,957		8,957	12
13	DD 16 OR LESS					13
14	TOTALS	9,452	15,973	187	25,612	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.83%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1973

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 32 and days of care provided 187

Medicare Intermediary AdminaStar Federal - Illinois

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 09/30/2004 Fiscal Year: 09/30/2004

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	179,160	7,168		186,328		186,328		186,328			1
2	Food Purchase		157,279		157,279		157,279	(2,150)	155,129			2
3	Housekeeping	38,381	15,523		53,904		53,904		53,904			3
4	Laundry	43,295	8,583	6,768	58,646		58,646	(10,901)	47,745			4
5	Heat and Other Utilities			72,800	72,800		72,800	1,279	74,079			5
6	Maintenance	47,760	34,218	28,268	110,246		110,246		110,246			6
7	Other (specify):*											7
8	**TOTAL General Services**	308,596	222,771	107,836	639,203		639,203	(11,772)	627,431			8
	B. Health Care and Programs											
9	Medical Director			10,800	10,800		10,800		10,800			9
10	Nursing and Medical Records	931,116	65,673	67,288	1,064,077		1,064,077		1,064,077			10
10a	Therapy			9,449	9,449		9,449		9,449			10a
11	Activities	61,989	14,108	2,357	78,454		78,454		78,454			11
12	Social Services	22,745		2,361	25,106		25,106		25,106			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,015,850	79,781	92,255	1,187,886		1,187,886		1,187,886			16
	C. General Administration											
17	Administrative	90,078			90,078		90,078	25,000	115,078			17
18	Directors Fees											18
19	Professional Services			80,411	80,411		80,411	1,200	81,611			19
20	Dues, Fees, Subscriptions & Promotions			13,445	13,445		13,445	(451)	12,994			20
21	Clerical & General Office Expenses	35,649	6,636	30,292	72,577		72,577	663	73,240			21
22	Employee Benefits & Payroll Taxes			338,076	338,076		338,076	1,683	339,759			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,327	16,327		16,327	(4,065)	12,262			24
25	Other Admin. Staff Transportation			12,209	12,209		12,209		12,209			25
26	Insurance-Prop.Liab.Malpractice			55,574	55,574		55,574		55,574			26
27	Other (specify):*											27
28	**TOTAL General Administration**	125,727	6,636	546,334	678,697		678,697	24,030	702,727			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,450,173	309,188	746,425	2,505,786		2,505,786	12,258	2,518,044			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alpine Fireside Health Center #0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			38,201	38,201		38,201	55,296	93,497			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,222	11,222		11,222	41,450	52,672			32
33	Real Estate Taxes							52,043	52,043			33
34	Rent-Facility & Grounds			275,100	275,100		275,100	(275,100)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			324,523	324,523		324,523	(126,311)	198,212			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		7,646		7,646		7,646		7,646			39
40	Barber and Beauty Shops			13,213	13,213		13,213		13,213			40
41	Coffee and Gift Shops			45	45		45	(45)				41
42	Provider Participation Fee			35,125	35,125		35,125		35,125			42
43	Other (specify):* Nonallowable Costs			19,650	19,650		19,650	(19,300)	350			43
44	**TOTAL Special Cost Centers**		7,646	68,033	75,679		75,679	(19,345)	56,334			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,450,173	316,834	1,138,981	2,905,988		2,905,988	(133,398)	2,772,590			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(467)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,329	30		9
10	Interest and Other Investment Income	(917)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(209)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,000)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,994)	43		24
25	Fund Raising, Advertising and Promotional	(3,428)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,391)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,642)	43		28
29	Other-Attach Schedule See attached Schedule 5a	(14,292)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (33,011)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(100,387)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (100,387)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (133,398)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Alpine Fireside Health Center
Provider #: 0018275
10/01/2003 to 09/30/2004 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference
Laundry income offset	(10,901)	4
Non-allowable dues	(451)	20
Non-allowable out of state seminars	(3,635)	24
Non-allowable out of state travel	(1,624)	24
Store sales offset	(45)	41
Loss on sale of fixed assets	(1,542)	43
Miscellaneous	3,906	43
Total	**(14,292)**	

SEE ACCOUNTANTS' COMPILATION REPORT

Alpine Fireside Health Center

ID# 0018275

Report Period Beginning: 10/01/2003

Ending: 09/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alpine Fireside Health Center **#** 0018275 **Report Period Beginning:** 10/01/2003 **Ending:** 09/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(467)	0	0	0	0	0	0	0	0	0	0	(467)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,279	0	0	0	0	0	0	0	0	0	1,279	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(467)	1,279	0	0	0	0	0	0	0	0	0	812	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	25,000	0	0	0	0	0	0	0	0	0	25,000	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,200	0	0	0	0	0	0	0	0	0	1,200	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	663	0	0	0	0	0	0	0	0	0	663	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,194	0	0	0	0	0	0	0	0	0	1,194	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	28,057	0	0	0	0	0	0	0	0	0	28,057	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(467)	29,336	0	0	0	0	0	0	0	0	0	28,869	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alpine Fireside Health Center # 0018275 **Report Period Beginning:** 10/01/2003 **Ending:** 09/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	4,329	50,967	0	0	0	0	0	0	0	0	0	55,296	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(917)	42,367	0	0	0	0	0	0	0	0	0	41,450	32
33	Real Estate Taxes	0	52,043	0	0	0	0	0	0	0	0	0	52,043	33
34	Rent-Facility & Grounds	0	(275,100)	0	0	0	0	0	0	0	0	0	(275,100)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,412	(129,723)	0	0	0	0	0	0	0	0	0	(126,311)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(21,664)	0	0	0	0	0	0	0	0	0	0	(21,664)	43
44	**TOTAL Special Cost Centers**	(21,664)	0	0	0	0	0	0	0	0	0	0	(21,664)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(18,719)	(100,387)	0	0	0	0	0	0	0	0	0	(119,106)	45

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Johs Oksnevad	100			Johs Oksnevad	Rockford, IL	Real estate lessor

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Fees	$	Johs Oksnevad	100.00%	$ 1,200	$ 1,200	1
2	V	21	Office		Johs Oksnevad	100.00%	663	663	2
3	V	24	Travel and seminar		Johs Oksnevad	100.00%	1,194	1,194	3
4	V	30	Depreciation		Johs Oksnevad	100.00%	50,967	50,967	4
5	V	32	Interest		Johs Oksnevad	100.00%	42,367	42,367	5
6	V	33	Real estate taxes		Johs Oksnevad	100.00%	52,043	52,043	6
7	V	34	Rent - facility and grounds	275,100	Johs Oksnevad	100.00%		(275,100)	7
8	V	5	Heat and other utilities		Johs Oksnevad	100.00%	1,279	1,279	8
9	V	17	Assistant Administrator salary		Johs Oksnevad	100.00%	25,000	25,000	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 275,100			$ 174,713	$ * (100,387)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Johs Oksnevad	President	Asst Administrator	100.00	0	20	50.00	Salary	$ 25,000	L17, C8	1
2	Gordon Oksnevad	Administrator	Administrator	0.00		40 +	100.00	Salary	90,078	L17, C1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 115,078		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Durand Bank		x	Working capital & improvemen	$10,000.00	12/01	$ 915,387	$ 732,385	2016	0.0575	$ 42,367	1
2	US Bank		x	Auto	$813.44	2/25/04	43,115	32,998	2/25/09	0.0499	1,082	2
3												3
4												4
5												5
	Working Capital											
6	Johs Oksnevad	x		Working capital	None	9/30/99	169,000	204,520	Demand	0.0600	10,140	6
7												7
8												8
9	TOTAL Facility Related				$10,813.44		$ 1,127,502	$ 969,903			$ 53,589	9
	B. Non-Facility Related*											
10												10
11								Offset interest income			(917)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (917)	14
15	TOTALS (line 9+line14)						$ 1,127,502	$ 969,903			$ 52,672	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.		$ 40,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ 52,043	2
3. Under or (over) accrual (line 2 minus line 1).		$ 12,043	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 40,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 52,043	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	46,017	8
	2000	48,992	9
	2001	49,998	10
	2002	51,615	11
	2003	52,043	12

Accrual calculation	
2003 tax bill	52,043
% increase	1.01
Estimated 2004 taxes	52,563 x 9/12 = 39,433 - use 40,000

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alpine Fireside Health Cente COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0018275

CONTACT PERSON REGARDING THIS REPORT Gordon Oksnevad

TELEPHONE (815) 877-7408 FAX #: (815) 877-9818

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-05-376-003	Nursing home	$ 52,043.00	$ 52,043.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 52,043.00	$ 52,043.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,000 B. General Construction Type: Exterior Brick Frame Concrete / steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient care	2.8 acres	1961	$ 10,000	1
2					2
3	TOTALS	2.8 acres		$ 10,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	93		1973	1973	$ 717,727	$	30	$	$	$ 717,727	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9				1973	1,277		10			1,277	9
10				1973	3,172		20			3,172	10
11				1973	694		40	17	17	544	11
12				1973	201		25			201	12
13				1973	93,791		11			93,791	13
14				1973	96,886		34	2,850	2,850	76,522	14
15				1974	8,366		11			8,366	15
16				1975	3,593		10			3,593	16
17				1977	10,055		10			10,055	17
18				1981	2,656		15			2,656	18
19				1982	5,132		11			5,132	19
20				1982	1,063		15			1,063	20
21				1984	21,939		15			21,939	21
22	Smoke detectors			1984	1,145		10			1,145	22
23				1985	3,300		15			3,300	23
24	Roof			1986	19,094		15			19,094	24
25	Kitchen addition and storm sewers			1988	235,818		20	11,791	11,791	194,551	25
26	Kitchen improvements			1989	9,541		20	477	477	7,632	26
27	Black top			1990	5,000		10			5,000	27
28	Broiler			1991	29,033		20	1,452	1,452	19,602	28
29	Lawn sprinkler			1992	5,000		15	333	333	3,997	29
30	Leasehold improvements			1993	13,972		15	931	931	10,707	30
31	Roof improvements			1994	57,648		15	3,843	3,843	40,530	31
32	Generator			1995	34,924		15	2,328	2,328	22,116	32
33	Air conditioning system			1999	280,820		15	18,721	18,721	102,966	33
34	Carpeting / flooring / wall covering			1999	81,812		15	5,454	5,454	29,997	34
35	Parking lot lights			1999	16,900		15	1,126	1,126	6,193	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Air conditioning	2000	$ 24,655	$	15	$ 1,644	$ 1,644	$ 5,754	37
38	Parking lot	2002	42,683	2,846	15	2,846		7,115	38
39	Boiler electrical improvements	2002	11,560	578	20	578		1,445	39
40	Gazebo pad	2002	12,657	633	20	633	0	1,582	40
41	Painting and wallpapering hallways	2003	27,403	1,370	20	1,370	(0)	2,055	41
42	Gazebo	2003	35,825	1,792	20	1,792	(0)	2,688	42
43	Fence	2003	3,400	170	20	170		255	43
44	Sign	2003	1,675	84	20	84	0	126	44
45	Garage	2003	3,077	154	20	154	0	230	45
46	Fire alarm	2003	30,208	1,510	20	1,510		2,265	46
47	Boiler	2004	31,880	797	20	797		797	47
48	Sign	2004	3,487	87	20	87		87	48
49	Smoke detectors	2004	2,153	54	20	54		54	49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,991,222	$ 10,075		$ 61,042	$ 50,967	$ 1,437,321	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 324,026	$ 14,906	$ 14,906	$	3-10 yrs	$ 257,153	71
72	Current Year Purchases	3,093	309	309		3-5 yrs	309	72
73	Fully Depreciated Assets	303,476					303,476	73
74								74
75	TOTALS	$ 630,595	$ 15,215	$ 15,215	$		$ 560,938	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Administrative	2004 Yukon	2004	$ 53,115	$ 5,312	$ 5,312	$	5	$ 5,312	76
77	Maintenance truck	Dodge Ram 2500	2003	29,535	5,907	5,907		5	8,861	77
78	Resident transportation	1998 Chevy Venture M/V	2002	5,480	1,096	1,096		5	2,740	78
79	Resident transportation	1998 Ford Supreme Bus	1999	49,247		4,925	4,925	5	49,247	79
80	TOTALS			$ 137,377	$ 12,315	$ 17,240	$ 4,925		$ 66,160	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	2,769,194	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	37,605	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	93,497	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	55,892	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	2,064,419	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction -in-progress	$ 9,240	92
93			93
94			94
95		$ 9,240	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
[ ] YES
[X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10a, C3	hrs	$	114	$ 5,685	$	114	$ 5,685	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C3	hrs		75	3,764		75	3,764	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				7,646		7,646	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	189	$ 9,449	$ 7,646	189	$ 17,095	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Alpine Fireside Health Center
Provider #: 0018275
10/01/2003 to 09/30/2004 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (93,313)	$ (93,313)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,000)	215,021	215,021	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,513	49,513	6
7	Other Prepaid Expenses	16,779	16,779	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposits	33,198	33,198	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 221,198	$ 221,198	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		10,000	13
14	Buildings, at Historical Cost	206,007	1,991,222	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	325,963	767,972	16
17	Accumulated Depreciation (book methods)	(163,382)	(2,064,419)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Const. in Progress	9,240	9,240	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 377,828	$ 714,015	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 599,026	$ 935,213	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 51,722	$ 51,722	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	212,823	212,823	29
30	Accrued Salaries Payable	30,845	30,845	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,704	3,704	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,000	40,000	32
33	Accrued Interest Payable	20,255	20,255	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,635	1,635	35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 360,984	$ 360,984	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	24,695	757,080	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 24,695	$ 757,080	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 385,679	$ 1,118,064	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 213,347	$ (182,851)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 599,026	$ 935,213	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,540,195)	1
2	Restatements (describe):		2
3	**Prior period adjustment**	(55,230)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,595,425)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,372)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Forgiveness of prior years' accrued rent**	1,811,144	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,808,772	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 213,347	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,827,894	1
2	Discounts and Allowances for all Levels	16,533	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,844,427	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,620	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 9,620	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	24,083	13
14	Non-Patient Meals	467	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,725	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	10,901	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 40,176	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	917	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 917	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	8,476	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,476	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,903,616	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	639,203	31
32	Health Care	1,187,886	32
33	General Administration	678,697	33
	B. Capital Expense		
34	Ownership	324,523	34
	C. Ancillary Expense		
35	Special Cost Centers	40,554	35
36	Provider Participation Fee	35,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,905,988	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,372)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,372)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Tax return is filed using the cash basis of accounting.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Alpine Fireside Healthcare, Ltd.
PROVIDER # 0018275
9/30/2004

Schedule 19A

XVII. INCOME STATEMENT

Revenue

E. Other Revenue (specify):	Amount
Store and miscellaneous sales	6,047
Miscellaneous Income	2,429
Total Line 28 - Other Revenue (specify):	**8,476**

See Accountants' Compilation Report

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 64,630	$ 31.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,015	4,229	97,528	23.06	3
4	Licensed Practical Nurses	10,798	11,144	201,213	18.06	4
5	Nurse Aides & Orderlies	43,076	44,679	460,238	10.30	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,543	2,663	36,034	13.53	8
9	Activity Director	1,513	1,560	23,492	15.06	9
10	Activity Assistants	5,119	5,183	38,497	7.43	10
11	Social Service Workers	1,801	1,953	22,745	11.65	11
12	Dietician	2,080	2,080	40,026	19.24	12
13	Food Service Supervisor					13
14	Head Cook	5,111	5,379	41,200	7.66	14
15	Cook Helpers/Assistants	13,973	14,330	97,934	6.83	15
16	Dishwashers					16
17	Maintenance Workers	2,634	2,818	47,760	16.95	17
18	Housekeepers	4,983	5,167	38,381	7.43	18
19	Laundry	4,307	4,403	43,295	9.83	19
20	Administrator	2,080	2,080	90,078	43.31	20
21	Assistant Administrator	1,040	1,040	25,000	24.04	21
22	Other Administrative					22
23	Office Manager	2,046	2,158	32,951	15.27	23
24	Clerical	196	200	2,698	13.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca See Sch 20A	3,762	3,946	71,473	18.11	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	113,157	117,092	$ 1,475,173 *	$ 12.60	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	10,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	812	1,694	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	118	2,357	L11, C3	44
45	Social Service Consultant	118	2,361	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,048	$ 17,212		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	722	$ 28,873	L10, C3	50
51	Licensed Practical Nurses	1,102	36,562	L10, C3	51
52	Nurse Aides	8	159	L10, C3	52
53	TOTAL (lines 50 - 52)	1,832	$ 65,594		53

SEE ACCOUNTANTS' COMPILATION REPORT

Alpine Fireside Health Center, Ltd.
PROVIDER # 0018275
September 30, 2004

Schedule 20A

XVIII. STAFFING AND SALARY COSTS
LINE 31 - Other (specify)

	Hours Worked	Hours Paid	Salary	Avg Hr Wage
MDS Plan Coordinator	1,713	1,857	41,986	22.61
Resident Service Coordinator	2,049	2,089	29,487	14.12
Total Line 31 - Other	**3,762**	**3,946**	**$ 71,473**	**$ 18.11**

See Accountants' Compilation Report

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Johs Oksnevad	Asst Administrator	100	$ 25,000
Gordon Oksnevad	Administrator	0	90,078
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 115,078

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris LLP	Legal	$ 12,547
American Express Tax & Bus Svce	Accounting	23,108
Altschuler Melvoin & Glasser LLP	Accounting	15,701
Keane Care Inc	Computer consulting	20,102
Business Mgmt Service	Computer consulting	7,493
Kronos	Time clock	750
Resources Systems	Computer consulting	710
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 80,411

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 94,545
Unemployment Compensation Insurance	22,335
FICA Taxes	100,246
Employee Health Insurance	101,332
Employee Meals	1,683
Illinois Municipal Retirement Fund (IMRF)*	
Pre-employment physicals	8,047
Uniforms	1,571
401 (k)	10,000
TOTAL (agree to Schedule V, line 22, col.8)	$ 339,759

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,990
Health Care Worker Background Check	
(Indicate # of checks performed 141)	1,696
Illinois Health Care Association dues	5,076
Miscellaneous subscriptions	1,530
Miscellaneous licenses	702
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,994

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,113
Seminar Expense	10,149
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,262

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Alpine Fireside Health Center
Provider #: 0018275
10/01/2003 to 09/30/2004 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	80,411
Professional fees allocated from facility owner	1,200
Total (agree to Schedule V, line 19, column 8)	81,611

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Health Care Assn - $ 5,076**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **4**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **12,741** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **x** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **35,125**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **1,683** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **467**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **-0-**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	179,160	7,168	0	186,328	0	186,328	0	186,328
2. Food Purchase	0	157,279	0	157,279	0	157,279	-2,150	155,129
3. Housekeeping	38,381	15,523	0	53,904	0	53,904	0	53,904
4. Laundry	43,295	8,583	6,768	58,646	0	58,646	-10,901	47,745
5. Heat and Other Utilities	0	0	72,800	72,800	0	72,800	1,279	74,079
6. Maintenance	47,760	34,218	28,268	110,246	0	110,246	0	110,246
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	308,596	222,771	107,836	639,203	0	639,203	-11,772	627,431
9. Medical Director	0	0	10,800	10,800	0	10,800	0	10,800
10. Nursing & Medical Records	931,116	65,673	67,288	1,064,077	0	1,064,077	0	1,064,077
10a. Therapy	0	0	9,449	9,449	0	9,449	0	9,449
11. Activities	61,989	14,108	2,357	78,454	0	78,454	0	78,454
12. Social Services	22,745	0	2,361	25,106	0	25,106	0	25,106
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,015,850	79,781	92,255	1,187,886	0	1,187,886	0	1,187,886
17. Administrative	90,078	0	0	90,078	0	90,078	25,000	115,078
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	80,411	80,411	0	80,411	1,200	81,611
20. Fees, Subscriptions & Promotion	0	0	13,445	13,445	0	13,445	-451	12,994
21. Clerical & General Office	35,649	6,636	30,292	72,577	0	72,577	663	73,240
22. Employee Benefits & Payroll	0	0	338,076	338,076	0	338,076	1,683	339,759
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	16,327	16,327	0	16,327	-4,065	12,262
25. Other Admin. Staff Trans	0	0	12,209	12,209	0	12,209	0	12,209
26. Insurance-Prop.Liab.Malpractice	0	0	55,574	55,574	0	55,574	0	55,574
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	125,727	6,636	546,334	678,697	0	678,697	24,030	702,727
29. Total General Administrative	1,450,173	309,188	746,425	2,505,786	0	2,505,786	12,258	2,518,044
30. Depreciation	0	0	38,201	38,201	0	38,201	55,296	93,497
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	11,222	11,222	0	11,222	41,450	52,672
33. Real Estate	0	0	0	0	0	0	52,043	52,043
34. Rent - Facility & Grounds	0	0	275,100	275,100	0	275,100	-275,100	0
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	324,523	324,523	0	324,523	-126,311	198,212
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	7,646	0	7,646	0	7,646	0	7,646
40. Barber and Beauty Shop	0	0	13,213	13,213	0	13,213	0	13,213
41. Coffee and Gift Shops	0	0	45	45	0	45	-45	0
42	0	0	35,125	35,125	0	35,125	0	35,125
43. Other (specify):*	0	0	19,650	19,650	0	19,650	-19,300	350
44. Total Special Cost Ce	0	7,646	68,033	75,679	0	75,679	-19,345	56,334
45. Grand Total	1,450,173	316,834	1,138,981	2,905,988	0	2,905,988	-133,398	2,772,590

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-93,313	-93,313
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	215,021	215,021
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	49,513	49,513
7. Other Prepaid Expenses	16,779	16,779
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	33,198	33,198
10. Total current assets	221,198	221,198
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	10,000
14. Buildings, at Historical Cost	206,007	1,991,222
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	325,963	767,972
17. Accumulated Depreciation (book methods)	-163,382	-2,064,419
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	9,240	9,240
23. other (specify):	0	0
24. Total Long-Term Assets	377,828	714,015
25. Total Assets	599,026	935,213
CURRENT LIABILITIES		
26. Accounts Payable	51,722	51,722
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	212,823	212,823
30. Accrued Salaries Payable	30,845	30,845
31. Accrued Taxes Payable	3,704	3,704
32. Accrued Real Estate Taxes	40,000	40,000
33. Accrued Interest Payable	20,255	20,255
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	1,635	1,635
36. Other Current Liabilities (specify):	0	0
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	360,984	360,984
LONG TERM LIABILITES		
39.Long-Term Notes Payable	24,695	757,080
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	24,695	757,080
46.Total Liabilities	385,679	1,118,064
47.Total Equity	213,347	-182,851
48.Total Liabilities and Equity	599,026	935,213

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,827,894
2. Discounts and Allowances for all Levels	16,533
Subtotal - Inpatient Care	2,844,427
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	9,620
7. Oxygen	0
Subtotal - Anciliary Revenue	9,620
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	24,083
14. Non-Patient Meals	467
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	4,725
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	10,901
Subtotal - Other Operating Revenue	40,176
24. Contributions	0
25. Interest and Other Investments Income	917
Subtotal - Non-Operating Revenue	917
27. Other Revenue (specify):	0
28. Other Revenue (specify):	1,819,620
Subtotal - Other Revenue	1,819,620
30. Total Revenue	4,714,760
31. General Services	639,203
32. Health Care	1,187,886
33. General Administration	703,697
34. Ownership	299,523
35. Special Cost Centers	40,554
35. Provider Participation Fee	35,125
37. Other	0
40. Total Expenses	2,905,988
41. Income Before Income Taxes	1,808,772
42. Income Taxes	0
43. Net Income or Loss for the Year	1,808,772

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